

BEFORE THE KANSAS WORKERS COMPENSATION APPEALS BOARD

RONALD P. NUNES
Claimant

V.

BUCKLEY INDUSTRIES, INC.
Respondent

AND

CHARTER OAK FIRE INSURANCE CO.
Insurance Carrier

Docket No. 1,007,315

ORDER

Respondent and insurance carrier (respondent), by William Townsley, request review of Administrative Law Judge Thomas Klein's August 13, 2015 Post-Award Medical Award. Robert Lee appears for claimant. The case is on the summary docket for disposition without oral argument.

ISSUES

In the Post-Award Medical Award, the judge stated:

The court finds Dr. Parks to be in the best position to interpret what care and treatment the claimant requires from a pain management perspective. Dr. Parks remains the authorized treating physician for pain management. He is authorized to perform whatever pain management services . . . in his discretion and [judgment], are necessary to cure and relieve the effects of claimant's work injury.

Respondent requests the Award be reversed, arguing Dr. Parks' recent treatment was not related to the initial and compensable work-related injury. The original injury, according to respondent, involved surgical excision of claimant's L1-2 disc, but Dr. Parks' injections in 2013-14 involved L4-5 and L5-S1. Respondent contends the treatment was not appropriate when considering the reported effectiveness of the procedure and the requirements of the *Official Disability Guidelines* (ODG). Respondent "seeks to discontinue all treatment at L3-L4, L4-L5 and L5-S1 including epidural steroid injections, transforaminal epidural injections and trigger point injections, because there is no relevant or credible medical theory that supports any causation relationship."¹

¹ Respondent's Brief at 2.

Claimant maintains the Award should be affirmed. Claimant argues Drs. Stein and Parks testified he still needs medical care to relieve him of the effects of the work-related injury. Claimant asserts it would be inappropriate to discontinue medical benefits or allow respondent to micromanage Dr. Parks' treatment.

The issues concern whether Dr. Parks' medical treatment is causally related to claimant's injury and reasonable and necessary to relieve the effects of such injury?

FINDINGS OF FACT²

Claimant, currently 66 years old, injured his low back working for respondent on July 10, 2002. Paul Stein, M.D., a neurosurgeon, began treating claimant in August of 2002, and was appointed by the court as the authorized treating physician. Dr. Stein initially diagnosed claimant with a lumbar strain with degenerative disc disease. Dr. Stein provided claimant conservative treatment, including physical therapy, as well as injections through Ronald R. Manasco, M.D. According to Dr. Manasco, claimant's MRI showed degenerative disk disease from L1 to L4, a right-sided bulging disc at L3-4 and central stenosis at L3-4. On October 7, 2002, Dr. Manasco administered an epidural steroid block at L3-4.

In February 2003, Dr. Stein placed claimant at maximum medical improvement. In July 2003, claimant returned to Dr. Stein and complained of lower back and left anterior thigh pain after bending over to tie a trash bag the previous month. Claimant reported his pain was intractable and he had left thigh numbness. Claimant had a lumbar myelogram and CT scan showing a left-sided disk extrusion at L1-2, but no other levels had significant bulging or herniation. Dr. Stein diagnosed claimant with a left-sided, moderately large L1-2 disc herniation with nerve root irritation. Dr. Manasco administered a nerve block on August 18, 2003. Dr. Manasco again noted an MRI showed degenerative disc disease at L1 to L4 and stenosis at L3-4. A September 23, 2003 CT scan showed a disc extrusion at L1-2 and mild to moderate degenerative changes at the facets.

Dr. Stein likely referred claimant to Jacob Amrani, M.D., who performed an L1-2 discectomy on October 13, 2003. Following additional, unsuccessful treatment to reduce claimant's pain, Dr. Stein referred him to Jon Parks, M.D., who is board certified in anesthesia, for pharmacologic pain management.

Dr. Parks began treating claimant in January 2004. He tried to reduce claimant's pain and maintain his function with treatment consisting of pain medication, epidural injections and muscular trigger point injections. X-rays taken on September 20, 2004, ordered by Dr. Parks, showed disc space narrowing at L1-2 and degenerative changes at the L5-S1 facet joint.

² The Board has carefully considered the entire evidentiary record.

On March 2, 2005, an Award approved by the parties was entered granting claimant permanent partial disability benefits and future medical treatment. The Award stated Dr. Stein was the authorized treating physician and pain management with Dr. Parks was authorized based on a referral from Dr. Stein.

Dr. Parks ordered a lumbar MRI on February 25, 2008, due to claimant having postlaminectomy syndrome with increasing left lower extremity radiating pain. Claimant had a lumbar MRI on March 6, 2008. Dr. Parks noted the MRI showed disc herniations at L2-3, L3-4, L4-5 and bulging at L5-S1, arthritic-like changes to the facet joints and narrowing of the neural foramen. Further, Dr. Parks stated claimant had surgery involving L3-4 with John R. Dickerson, M.D., after the 2008 MRI.³

In August 2010, claimant was severely beaten, tossed down his home basement stairs and left for three or four days tied up until police found him. He suffered a traumatic brain injury, facial lacerations and a left knee fracture. Following the assault, Dr. Parks deferred the handling of claimant's pain medication to the Veterans Administration (VA), but he continued treating and administering injections as needed for pain relief.

Dr. Parks and his staff diagnosed claimant with postlaminectomy syndrome of the lumbar spine, chronic low back radicular symptoms with lumbar disc disease, low back pain with bilateral sacroiliac joint arthralgia and chronic myofascial pain. Dr. Parks' records show his physician assistant (P.A.), Rita Simpson, gave claimant six trigger point injections on January 15 and again on March 12, 2013. Dr. Parks provided a transforaminal epidural steroid injection at L3-4 on May 7, 2013. P.A. Simpson gave four trigger point injections on May 14, 2013, three trigger point injections on July 15, 2013, and six trigger point injections on September 13, 2013. All trigger point injections were to two muscle groups, presumably in claimant's low back.

On November 14, 2013, claimant reported his last trigger point injections relieved greater than 80% of his low back pain. P.A. Simpson administered six trigger point injections in two muscle groups. Claimant received eight trigger point injections in two muscle groups on January 14, 2014, and four trigger point injections in two muscle groups on both May 7 and July 9, 2014.

On July 11, 2014, respondent denied authorization for an L4-5 epidural steroid injection due to there being "No Objective Findings."⁴ Three days later, on July 14, 2014, claimant reported increasing low back pain radiating into his hip and occasionally front to back of legs. P.A. Simpson recommended a lumbar epidural, with which Dr. Parks agreed.

³ The specific surgery, such as a fusion or laminectomy, is not explained in the record. Neither is it explained if such surgery was paid under workers compensation insurance.

⁴ Parks Depo., Ex. 7.

On July 18, 2014, respondent denied authorizing trigger point injections because they lacked medical documentation and did not “meet medical necessity guidelines.”⁵

VA records show claimant was provided a wheelchair on July 28, 2014, because he was not able to ambulate long distances secondary to severe bilateral leg pain and increased edema. Claimant wanted the wheelchair because he had fallen at home a couple times, but reported no resulting health consequences. A couple days later, claimant told a VA nurse practitioner that he had been regularly using a walker at home for support.

On July 29, 2014, respondent denied authorization of Dr. Parks’ trigger point injections administered on May 7 and July 9, 2014, because there was no clear discussion regarding claimant’s response to the January 14, 2014 injection.

Claimant reported on July 29, 2014, that his last epidural on September 20, 2011, provided 60-80% relief and all trigger injections provide 50-70% relief or greater. A July 22, 2014 MRI showed severe degenerative disc disease at L3-4 through L5-S1, L2-3 spondylosis with broad-based disc bulge and moderate central and nerve root narrowing, L3-4 broad-based disc bulge with central stenosis, bilateral neural foraminal stenosis and facet arthropathy, L4-5 spondylolisthesis, facet arthropathy with facet cyst on the right pushing into the nerve root, broad-based disc bulge with ligamentous hypertrophy, central canal stenosis and neural foraminal stenosis, and L5-S1 spondylosis, facet arthropathy, facet cyst to the right pushing into the nerve root and disc bulge to the right pushing into the nerve root. Dr. Parks testified claimant’s MRI showed multi-level degenerative changes, but did not reflect the prior severe degenerative changes from L3 to S1, and there continued to be facet changes throughout the lumbar spine, including nerve root narrowing, and central canal stenosis at one level. P.A. Simpson recommended a lumbar epidural as soon as possible and trigger point injections as necessary. Dr. Parks agreed.

Claimant reported low back pain on August 11, 2014. Dr. Parks administered a transforaminal epidural steroid injection at L4-5. The injection resulted in a 65-70% reduction of pain. On September 10, 2014, Dr. Parks provided another transforaminal epidural steroid injection at L4-5 which resulted in a 60% reduction of pain. On September, 26, 2014, Dr. Parks gave another transforaminal epidural steroid injection at L4-5 which resulted in 50% reduction of pain.

On October 15, 2014, claimant requested a repeat transforaminal epidural steroid injection at L4-5. A week later, respondent denied authorization for the injection because it did not meet medical necessity guidelines. As a result, claimant filed for post-award medical treatment and attorney fees on October 24, 2014.

⁵ *Id.*, Ex. 8.

Claimant returned to Dr. Stein on October 27, 2014, the first time the doctor examined claimant after January 21, 2004. Dr. Stein's report stated:

Mr. Nunes has severe degenerative disk and facet joint disease at multiple levels on his recent lumbar MRI scan. This appears to be significantly greater than the previous studies would indicate in my reports. That is the natural and expected consequence of the degenerative disease and not specifically related to the original work injury of 2002. The extent of the degeneration is such that I do not have any specific treatment recommendations. I did not believe that surgical intervention would be helpful [even if] Mr. Nunes were willing to consider it. In regard to the injections that were provided by Dr. Parks, I can state the following; 1. The injections will not be curative. 2. I cannot tell how much benefit was obtained from these injections except that Mr. Nunes feels they were very helpful. The relief obviously does not last very long as the injections were repeated relatively frequently. 3. It is of interest that the patient with so much degenerative disease obtains what he feels is substantial benefit from soft tissue, muscular trigger point injections. 4. It should be noted that Mr. Nunes says he has used a wheelchair for four or five months because he was not given injections. The medical records show that bilateral gluteal trigger point injections were given on 7/9/14 and transforaminal epidural steroid injections were given on 8/11/14 & 9/26/14.

In summary, I cannot make a definitive medical statement based upon objective evidence for or against further injections. I have no other recommendations for treatment. There is no reason for me to see this patient again.⁶

On November 17, 2014, Dr. Parks administered a transforaminal epidural steroid injection at L5-S1. His records stated the injection resulted in a 10% reduction of pain. However, in a subsequent report, claimant stated his 10% reduction in pain after the injection was incorrect and he actually had much more relief and he subsequently had return of his symptoms.

In a December 16, 2014 letter to respondent regarding the "relatedness" in prescribing pain medication, Dr. Parks and P.A. Simpson stated:

Mr. Nunes has continued to complain of increasing pain over the past year. Recommendations for transforaminal epidurals were made but due to the length of time between approvals the therapeutic threshold is lost and dissipates before any progress can be made leaving us to start from the beginning with each injection. Our only other recourse is to treat with oral medications to provide some assistance with pain relief. Denials for the epidurals have indicated injections are *to[o] close together* yet reviewing this with Dr. Parks he states there is no data to support waiting longer between injections proves to be beneficial.

⁶ Stein Depo., Ex. 2 at 3.

In "Pain Management" it is the standard of care AND our preference to treat aggressively with interventional care rather than throw medications at the problem. Medications are one of many resources however when avoidance to provide other therapeutic modalities during exacerbations is offered we have no other choice but to treat with medications. Interventional procedures allow us to treat the pain source quickly and directly reducing their pain, increasing functionality and decreasing their medication intake.

Mr. Nunes is suffering from a chronic diagnosis which he will endure over the remainder of his lifetime. Like any other disease process his pain is not curable however, as *pain specialist* we can assist in getting his pain under control, manage and maintain it at a tolerable level which I assume was the objective for referring him to Pain Management in the first place. *It needs to be said, the consistent denials and disruptions with our recommendations leaves us without the ability to make any progress for him.*⁷

Respondent had two physicians perform records review. Terrence Wilson, M.D., who is board certified in physical medicine and rehabilitation, performed a records review for Genex, but did not examine claimant. He is a salaried Genex employee and last treated a patient in 2004. Dr. Wilson testified the ODG requires observation and documentation of a certain degree of benefit from an epidural steroid injection before it is repeated. Dr. Wilson opined an additional L4-5 transforaminal epidural steroid injection was not medically necessary according to the ODG. He noted claimant had such injections on August 11, September 10 and September 26, 2014 and an additional injection was requested after October 15, 2014. In his opinion, the injections only provided short-term relief, not at least six to eight weeks of relief as noted in the ODG. Among other concerns, Dr. Wilson did not believe L4-5 was causing claimant's pain and he noted current research did not support providing a patient with even a series of three epidural steroid injections.

Sankar Pemmaraju, D.O., also board certified in physical medicine and rehabilitation, also performed a records review for Genex, but did not examine claimant. Dr. Pemmaraju primarily does consulting work and independent medical evaluations for insurance companies and peer review companies, such as Genex. Dr. Pemmaraju's report noted Dr. Parks' office wanted to perform an additional L5-S1 transforaminal epidural injection after the November 17, 2014 injection that provided claimant only 10% pain relief. Dr. Pemmaraju opined any additional L5-S1 transforaminal epidural steroid injection was not medically necessary according to the ODG, the medical findings, the physical exam findings and claimant's response to previous procedures. Dr. Pemmaraju noted a 50-70% improvement in pain for at least six to eight weeks would medically justify an injection, but a 10% reduction in pain did not warrant another injection.

⁷ Parks Depo., Ex. 4. (Emphasis in original.)

Dr. Stein testified he agreed with the opinions of Drs. Wilson and Pemmaraju insofar as he does not believe there is any objective evidence that further injections are going to be curative or provide long-term benefit. Dr. Stein opined claimant would benefit from reasonable medication for pain control. When questioned regarding the benefit of injections for pain management, Dr. Stein testified:

Certainly. If somebody gets injections that are providing 60, 70, 80 percent benefit, the use of narcotic medication should plummet. If the patient is unable to be up for more than ten minutes and if he's getting substantial relief, his ability to function should improve. Those would be as objective as you could get. In fact, you know, my philosophy is that - - let's say you want to do the injections because you think they might help but you don't have a good basis to say they will. Then what you do is outline a plan. I will do these injections over three periods of time. The patient will keep a pain log. We will continue to see whether he needs a wheelchair. We will continue to see whether he has reduced his pain substantially and is off narcotics. And if at the end of that time he can get along without the wheelchair and without the narcotics or with substantially reduced narcotics, then I would say yes, I would continue the injections. Otherwise, I would stop them. I would not do them forever and forever.⁸

Dr. Stein stated epidural steroid injections are invasive and should not be repeated unless a patient gets three or four months of good benefit. Still, he testified he could not make a definitive statement for or against further injections. Dr. Stein testified it was not his purview to say claimant should stop treating with Dr. Parks. Dr. Stein testified trigger point injections are for muscle pain and have nothing to do with degenerative disc disease.

Dr. Stein testified there was no evidence claimant's 2010 assault resulted in increased back pain, and the discharge summary following such event held no mention of a low back injury. Dr. Stein noted the assault could cause increased back pain, as could a gait disorder due to a knee injury or knee injuries after the assault.

The following dialogue occurred at Dr. Stein's deposition:

Q. [I]f our original injury was a surgery in 2004 for a large herniated disc at L1-L2, would you anticipate that the natural and probable consequence of that injury would result in the degenerative condition that you found at L4-L5 and L5-S1?

MR. LEE: I'll object to the form of the question. It assumes facts not in evidence. You can answer, Doctor.

A. No, I wouldn't expect it.⁹

⁸ Stein Depo. at 42-43.

⁹ *Id.* at 15.

Dr. Stein testified he would not be surprised if degenerative changes at L1-2 and L3-4 were related to claimant's injury, but changes at L4-5 and L5-S1 were not.¹⁰ Dr. Stein noted claimant's injury in 2002 was to the upper lumbar spine, not to L4-5 and L5-S1, at the lower level of the lumbar spine. Dr. Stein also testified he could not relate claimant's current level of degenerative disc disease to his 2002 injury.

Dr. Parks testified claimant had a workers compensation injury involving his spine and had significant changes throughout his lumbosacral spine and associated, continuing pain. Dr. Parks presumed claimant had inflamed nerves due to his spine. He stated a patient with irritated nerve roots gets muscle spasms, tightness and trigger points. Dr. Parks testified claimant has a lot of anatomic changes stemming from both the initial work-related injury and natural progression of the spine. As far back as when Dr. Parks commenced treating claimant, he treated areas of claimant's lumbosacral spine other than L2-3 and L3-4, including consistently getting good results with injections at L3-4 and L4-5.

While Dr. Parks acknowledged the assault against claimant "could easily exacerbate any chronic or any existing low back issue," he saw no documentation showing any long-term changes and observed he treated claimant for some of the same things before and after the assault.¹¹ Dr. Parks noted the weather, claimant's lack of sleep, sleeping on a couch and knee injury or injuries could potentially affect his level of pain.

When questioned regarding the necessity and purpose of injection therapy, Dr. Parks testified:

- Q. In your opinion, Doctor, within a reasonable degree of medical certainty, is the medication therapy which you were providing and the injection therapy you were providing necessary to cure and relieve him from the effects of his injury?
- A. I think cure would probably be an inappropriate term. Certainly will help relieve the symptoms of his injury. There's nothing I can do that will cure his underlying problems as far as what I can provide.
- Q. And that is the way it is in most back injury cases; you're not going to cure a failed-back injury syndrome like he has; your job, as least the way you see it, is to attempt to make life more livable and relieve his pain, true?
- A. Correct. My job is to try to relieve not only pain, but to maintain functionality. That's our goals of any pain practice.

...

¹⁰ *Id.* at 23, 38-40.

¹¹ Parks Depo. at 26, 47-50.

- Q. What purpose do the injections serve?
- A. The purpose of why we would do any type of injection in the spine in this situation would be to try to target steroid therapy towards where the place that we believe is most likely causing inflammation of nerve tissues and, thus, symptoms related to that.
- Q. The injections are very similar to the pain medications that you give and the pain medications are not curative, either, are they?
- A. No, they are not.
- Q. They are there to try to make Mr. Nunes more comfortable and with less pain, correct?
- A. Correct. As well as to try to keep him as functional as possible.¹²

Dr. Parks testified respondent's rationale for denying an additional L5-S1 procedure was correct based on claimant only having a 10% decrease in pain thereafter, and he would not recommend an additional injection at that level based on the results.¹³ However, he indicated respondent was wrong to deny injections at L4-5 because claimant had a 50% reduction in discomfort following such injections.

Dr. Parks was asked if he was treating claimant's injury or his degenerative lumbar condition:

- Q. All right. And as we're sitting here today, do you have an opinion as to whether the treatment you are providing is directly related to the initial injury or to his degenerative condition that exists in this 65-year-old man?
- A. To say that anyone could reliably totally separate those two, it would be incorrect. I mean, no one could say beyond a shadow of a doubt this one specific little item causing symptoms this day has no relation or is totally related to each other. But in generality based on the type of findings that were there in the distant past, when they were well-documented to be related to work comp and then what we have today, it seems to be just a continued progression of what was already there . . . [a]nd based on that I would extrapolate that the things we're treating today are related back and/or a natural progression of things that he had back when he has his initial injury.¹⁴

¹² *Id.* at 10-11, 17-18.

¹³ *Id.* at 44.

¹⁴ *Id.* at 46-47.

When comparing the 2008 and 2014 MRIs, Dr. Parks indicated the changes were “not unheard of in someone who has a natural progression of a spine that is a bad spine, if you will, throughout time.”¹⁵ Dr. Parks testified the 2014 MRI did not affect how he treated claimant’s injury. He further testified claimant still had the effects of his 2002 work injury and his low back condition was not solely due to degenerative disc disease. Dr. Parks was not sure it was proper to make a correlation between the need for trigger point injections due to myofascial pain and degenerative disc disease.

Claimant testified his condition gradually worsened after March 2005. He currently experiences pain across his low back and down his buttocks, which radiates into the calves of both legs. Claimant requires a wheelchair which he attributes to the severe pain in his buttocks because of the insurance carrier’s refusal to authorize injections recommended by Dr. Parks. Claimant testified he did not have pain in his buttocks before respondent denied his injections in July 2014. He testified injections “definitely” helped in controlling his pain.¹⁶ He noted respondent still provides him with Lidoderm patches that were prescribed by Dr. Parks.

PRINCIPALS OF LAW

K.S.A. 2002 Supp. 44-510k states the employer has a duty to provide an employee with medical treatment to cure and relieve the employee of the effects of the injury. K.S.A. 2002 Supp. 44-510k states a judge may award post-award medical treatment that is necessary to cure or relieve the effects of the accidental injury that was the subject of the underlying award.

The burden of proof is on claimant to establish his right to an award of compensation.¹⁷ Post-award medical treatment can be awarded if the need for medical care is necessary to cure or relieve the effects of the accidental injury which was the subject of the underlying award.¹⁸ An accidental injury is compensable even where the accident only aggravates or accelerates the condition.¹⁹

Every direct and natural consequence that flows from a compensable injury, including a new and distinct injury, is compensable. In *Jackson*, the court held:

¹⁵ *Id.* at 15.

¹⁶ P.A.H. Trans. at 8.

¹⁷ K.S.A. 44-501(a).

¹⁸ K.S.A. 2002 Supp. 44-510k(a).

¹⁹ *Woodward v. Beech Aircraft Corp.*, 24 Kan. App. 2d 510, 514, 949 P.2d 1149 (1997).

When a primary injury under the Workmen's Compensation Act is shown to have arisen out of the course of employment every natural consequence that flows from the injury, including a new and distinct injury, is compensable if it is a direct and natural result of a primary injury.²⁰

In *Logsdon*, the Kansas Court of Appeals noted:

1. *WORKERS COMPENSATION—Injury as Direct Result of Primary Injury—Question of Fact.* Whether an injury is a natural and probable result of previous injuries is generally a fact question.
2. *SAME—Injury as Direct Result of Primary Injury—Subsequent Injury Compensable if Primary Injury Arose Out of and In Course of Employment.* When a primary injury under the Worker's Compensation Act is shown to have arisen out of and in the course of employment, every natural consequence that flows from the injury, including a new and distinct injury, is compensable if it is a direct and natural result of a primary injury.
3. *SAME—Aggravation of Primary Injury for Which Compensation Awarded—Compensation Allowed for Postaward Medical Benefits.* When a claimant's prior injury has never fully healed, subsequent aggravation of that same injury, even when caused by an unrelated accident or trauma, may be a natural consequence of the original injury, entitling the claimant to postaward medical benefits.²¹

Nance states, "The passage of time in and of itself is not a compensable injury. Thus, where the deterioration would have occurred absent the primary injury, it is not compensable. However, where the passage of time causes deterioration of a compensable injury, the resulting disability is compensable as a direct and natural result of the primary injury."²² In *Nance*, "there was undisputed testimony that the primary injury had worsened, quite likely through the normal aging process and the passage of time. The worsening of a claimant's compensable injury, absent any intervening or secondary injury, is a natural consequence that flows from the injury. It is a direct and natural result of a primary injury. Since *Nance's* worsening back condition is merely a continuation of his original injury, causation is not an issue."²³

²⁰ *Jackson v. Stevens Well Service*, 208 Kan. 637, Syl. ¶ 1, 493 P.2d 264 (1972).

²¹ *Logsdon v. Boeing Company*, 35 Kan. App. 2d 79, Syl. ¶¶ 1, 2, 3, 128 P.3d 430 (2006).

²² *Nance v. Harvey County*, 263 Kan. 542, 550, 952 P.2d 411 (1997).

²³ *Nance v. Harvey County*, 23 Kan. App. 2d 899, 909, 937 P.2d 1245, *aff'd*, 263 Kan. 542, 952 P.2d 411 (1997).

In *Nance*, the Kansas Supreme Court noted that even though the doctor who testified about Nance's condition did not directly or affirmatively state "that the deterioration of Nance's injury is a direct and natural consequence of the first injury," such conclusion was the "inevitable result of his testimony."²⁴

ANALYSIS

Despite the prior order that Dr. Parks was authorized to provide pain management, respondent unilaterally disapproved injections his office requested. The proper procedure would have been for respondent to either request a change of physician or file an application for a post-award preliminary hearing. That being said, the dispute properly came to the judge on claimant's application for post-award medical and attorney fees. As a matter of enforcing the prior award, respondent is responsible to pay for Dr. Parks' treatment through the time this case was presented to and decided by the judge on this post-award matter.

Both physicians who actually examined claimant agreed claimant needs treatment for his low back and agreed claimant's current treatment will not cure his work-related injury. Of course, claimant need not prove Dr. Parks' treatment will cure him; the fact Dr. Parks' treatment provides him relief from the effects of the 2002 injury is sufficient.

There is insufficient proof claimant's current need for treatment is due to an intervening accidental injury. After claimant was beaten and thrown down his basement stairs, he was treated for various ailments, but not for low back pain in association with such assault. Claimant sleeping on a couch, not getting enough sleep or weather changes, all of which could cause increased back pain, are not intervening accidental injuries or valid reasons to sever the link between claimant's work injury and his need for treatment. The same is true for the possibility injury to claimant's knee or knees may have caused an altered gait which may have irritated or aggravated his back. Mere possibilities do not rise to the required level of proof – medical probability.²⁵

However, respondent arguably has valid reasons to question Dr. Parks' treatment regimen. First, at least part of claimant's current ailment is due to degenerative disc disease over time. *Nance*, however, holds that a respondent is still responsible for a claimant's compensable disability despite the worsening of such claimant's condition due to the passage of time. *Nance* seems to indicate that a worsening of a compensable injury, due to the passage of time and without an intervening accidental injury, is itself a direct and natural result of the injury. Claimant's 2002 accidental injury was compensable and he did not sustain any intervening accidental injuries.

²⁴ *Nance*, 263 Kan. at 553.

²⁵ See *Turner v. State*, No. 110,508, 2014 WL 3022644 (Kansas Court of Appeals unpublished opinion filed June 27, 2014).

Second, Dr. Parks acknowledged claimant should not receive an additional transforaminal epidural steroid injection to L5-S1 because he only had a 10% reduction in pain thereafter. Perhaps the 10% figure is incorrect based on claimant belatedly indicating he had significant improvement after the L5-S1 injection. Nonetheless, Dr. Parks unqualifiedly testified respondent's denial of an additional L5-S1 transforaminal epidural steroid injection was correct. The Board is reluctant to micromanage a physician's treatment. However, the current record shows an additional transforaminal epidural steroid injection at L5-S1 is medically unnecessary, largely based on Dr. Parks' testimony.

Third, Dr. Parks may be treating a different part of claimant's low back than what was originally injured in 2002. The record is not clear. Dr. Stein indicated claimant's degenerative L4-5 and L5-S1 discs have nothing to do with his 2002 injury that, according to the doctor, involved L1-2 and L3-4. Conversely, Dr. Parks testified that every treatment he provided claimant is due to his work injury or the direct and natural result thereof.

Fourth, Dr. Parks' epidural injections are arguably being done too frequently, as testified by Dr. Wilson and less emphatically stated by Dr. Stein. The general consensus is that epidurals should be administered only after six to eight weeks of good result, and longer based on Dr. Stein's testimony. Dr. Parks provided three L4-5 epidural steroid injections in 47 days (August 11 through September 26, 2014) and asked for yet another injection on October 15, 2015. However, we are still left with Dr. Stein's testimony and report that he has no opinion one way or the other regarding the necessity of the epidural steroid injections. Further, as noted above, we are loath to substitute our judgment for that of a board-certified physician who is highly familiar with claimant's medical treatment.

After careful review of the evidence, and placing emphasis on Dr. Parks' familiarity with claimant's condition over more than a decade's worth of treatment, we agree by a close margin that Dr. Parks is in the best position to assess what treatment is necessary to cure and relieve the effects of claimant's 2002 injury and the direct and natural progression thereof. Dr. Parks remains claimant's treating physician and may provide reasonable and necessary medical treatment, whether it be injections, medication or otherwise.

Regarding the trigger point injections, the physicians who did records reviews, Pemmaraju and Wilson, expressed no direct comment against the need for trigger point injections, instead focusing on whether transforaminal epidural steroid injections were reasonable and medically necessary. Dr. Stein had no opinion for or against the injections. As noted above, Dr. Parks testified the injections he provides claimant are due to his work injury or the direct and natural result of his work injury. The evidence demonstrates the trigger point injections Dr. Parks provided are reasonably necessary to relieve the effects of claimant's work injury.

CONCLUSIONS OF LAW

At this juncture of the claim and based on the evidence to date, respondent is not responsible for additional transforaminal epidural steroid injections directed at L5-S1. Dr. Parks remains claimant's authorized treating physician.

AWARD

WHEREFORE, the Board modifies the August 13, 2015 Post-Award Medical Award as set forth above.²⁶

IT IS SO ORDERED.

Dated this _____ day of November, 2015.

BOARD MEMBER

BOARD MEMBER

BOARD MEMBER

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²⁶ As required by K.S.A. 2014 Supp. 44-555c(j), all five members of the Board have considered the evidence and issues presented in this appeal. Accordingly, the findings and conclusions set forth above reflect the majority's decision and the signatures attest that this decision is that of the majority.